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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **AIYAN LI** **820 Evelyn Avenue** **Albany, CA 94706** **Registered Nurse License No. 693834** Respondent.	Case No. 2013-181 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs

2. On or about December 11, 2006, the Board of Registered Nursing issued Registered Nurse License Number 693834 to Aiyan Li (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2014, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section

references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

. . .

"(4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action.

. . ."

6. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

7. Section 118, subdivision (b), of the Code provides that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

8. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FACTUAL BACKGROUND

9. On or about September 20, 2010, while on duty at Napa State Hospital, Respondent was observed by a coworker to be sleeping while assigned to perform CIO (constant/in sight observation[1]) on a patient. Respondent's head was bowed and her eyes were closed. Coworkers attempted to get Respondent's attention by whistling at her, but she did not respond.

10. On or about September 22, 2010, while on duty at Napa State Hospital at approximately 1430 hours, Respondent began performing CIO on Patient A. At approximately 1435, Respondent abandoned Patient A by walking away from her position outside Patient A's room and entering the medication room in order to obtain rubber gloves.

11. On or about September 22, 2010, at approximately 1515 hours, Respondent falsified Patient A's medical record by incorrectly recording on his Napa State Hospital Enhanced Observation Record form of the same date and time, that Patient A was present in his room resting with his eyes closed. In fact, Patient A was not in his room, and Respondent failed to confirm Patient A's status prior to recording information on the Observation Record.

12. On or about September 22, 2010, at approximately 1520 hours, Respondent's shift lead observed Respondent sitting in a chair next to Patient A's closed door. Patient A was under CIO by Respondent. Respondent was facing in the opposite direction of Patient A's door and in the direction of the music room across the hall. When the shift lead asked Respondent where Patient A was, Respondent stated that he was in his room. In fact, Patient A, who was dangerous to himself and others, had left his room, unbeknownst to Respondent.

[1] Constant/In Sight Observation at Napa State Hospital requires "that patients shall always be in the direct line of sight of an assigned staff person who will be able to notice (emphasis added) and intervene if a dangerous incident occurs."

13. On or about September 22, 2010, at approximately 1700 hours, Respondent left the unit to which she was assigned at Napa State Hospital without prior knowledge and authorization of her shift lead.

14. On or about September 3, 2011, Respondent was observed to be asleep while on duty.

15. On or about September 4, 2011, Respondend escorted several patients to the chapel at Napa State Hospital. While in the chapel, Respodent was observed to have been sleeping for approximately 30 minutes. After the service, it was discovered that Respondent had lost her keys to Napa State Hospital facilities, and that a patient had possibly stolen them due to Respondent's inattention.

16. On or about November 8, 2010, Respondent was arrested due to a domestic disturbance. Respondent had an argument with her boyfriend, bit him on his knuckle and scratched his chest.

FIRST CAUSE FOR DISCIPLINE

(GROSS NEGLIGENCE)

17. Respondent is subject to disciplinary action under section 2761(a) in that she was grossly negligent as alleged above in paragraphs 9 through 14.

SECOND CAUSE FOR DISCIPLINE

(UNPROFESSIONAL CONDUCT)

18. Respondent is subject to disciplinary action under section 2761(a) in that she acted unprofessionally as alleged above in paragraphs 9 through 16.

THIRD CAUSE FOR DISCIPLINE

(DISCIPLINE BY ANOTHER STATE AGENCY)

19. Respondent is subject to disciplinary action under section 2761(a)(4) in that she received a Notice of Adverse Action from the California Department of Mental Health, citing "inexcusable neglect of duty," "insubordination," "dishonesty," "willful disobedience," and "other failure of good behavior either during or outside of duty hours which is of such a nature that it causes discredit to the appointing authority or the person's employment." The Notice of

Adverse Action was effective December 23, 2010, and arose from the incidents at Napa State Hospital listed above in paragraphs 9-13.

20. Respondent is further subject to disciplinary action under section 2761(a)(4) in that she received a Notice of Adverse Action from the California Department of Mental Health, citing "incompetency," "inefficiency," "inexcusable neglect of duty," "dishonesty," "discourteous treatment of the public or other employees," "willful disobedience," and "other failure of good behavior either during or outside of duty hours which is of such a nature that it causes discredit to the appointing authority or the person's employment." The Notice of Adverse Action was effective November 9, 2011, and arose from the incidents at Napa State Hospital listed above in paragraphs 14-15.

DISCIPLINE CONSIDERATIONS

21. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about November 30, 2010, in a prior action, the Board of Registered Nursing issued Citation Number 2010-1211 and ordered Respondent to pay a fine in the amount of $750.00 as a result of her failure to count controlled medications with the off-going medication person on February 1, 2010 at Napa State Hospital. That Citation is now final and is incorporated by reference as if fully set forth.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 693834, issued to Aiyan Li;

2. Ordering Aiyan Li to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

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3. Taking such other and further action as deemed necessary and proper.

DATED: September 12, 2012

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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